County of Hamilton

2013 Open Enrollment | *Verifications*

Open Enrollment
Effective Date 1/1/2013
Deadline to submit this form is 11/14/12

A. Employee General Information:

First Name:_____ Employee ID:_____ DOB:_____

Last Name:_____ Department #: _____

Home Phone: (_____) _____-_____ Email Address: _____

Street Address: _____
Street address *City* *State* *Zip Code*

B. MERP Enrollment information (Complete this section ONLY if electing MERP medical)

Alternate Coverage Information:

				HR Use Only
Alternate Coverage Provided through: (spouse, self, other)		Alternate Coverage Provider: (employer name, spouse employer name, organization name)		

Alternate Coverage Pay Frequency:
- ☐ Monthly
- ☐ Semi-Monthly
- ☐ Bi-Weekly
- ☐ Weekly

Contributions are Taken:
- ☐ After Taxes
- ☐ Before Taxes

Contribution Amounts Per Pay Period:
Premiums _____
Spousal Suchg _____

PLEASE ATTACH: a check stub, benefit confirmation, enrollment verification, or letter from Alternate Coverage provider to provide proof of premiums for your Alternate Coverage.
**Employees will not be reimbursed for Premium Contributions until proper verifications are received and verified.*

C. Dependent Information: *Supporting documentation is required when adding dependents.*

Complete this section only if you are <u>ADDING</u> a dependent that was not covered by your medical insurance, MERP, dental, or vision election in 2012. (For dependents covered in 2012, we previously received the verifications needed.)

If you are adding a dependent to dental coverage, and they are age 19-24, proof of full-time student status is required.

Spouse	Documentation Included for Spouse	HR Use Only
Name:_____ Date of Birth: ____-____-_____ Gender: M or F Medical or MERP ☐ Dental ☐ Vision ☐	☐ Copy of marriage license or certificate /divorce decree AND ☐ Copy of first page of most recent tax return (The dollar amounts can be marked out). AND ☐ <u>MERP ONLY</u>: Check Stub, Benefit Confirmation, Enrollment Verification, or letter from Alternate Coverage Provider verifying premium amounts.	

Dependent Child 1	Documentation Included for Dependent Child 1	HR Use Only
Name:_____ Date of Birth: ___-___-_____ Gender: M or F Dependent a full-time student? Yes ☐ No ☐ Dependent eligible for coverage through their employer? Yes ☐ No ☐ Medical or MERP ☐ Dental ☐ Vision ☐	☐ Copy of birth certificate/adoption paperwork/court order ☐ (If applicable) Copy of Social Security or physician certification of disability ☐ (If Age 19-24 and adding to dental) Proof of full-time student status	

Dependent Child 2	Documentation Included for Dependent Child 2	
Name:_____ Date of Birth: ___-___-____ Gender: M or F Dependent a full-time student? Yes ☐ No ☐ Dependent eligible for coverage through their employer? Yes ☐ No ☐ Medical or MERP ☐ Dental ☐ Vision ☐	☐ Copy of birth certificate/adoption paperwork/court order ☐ (If applicable) Copy of Social Security or physician certification of disability ☐ (If Age 19-24 and adding to dental) Proof of full-time student status	HR Use Only

Dependent Child 3	Documentation Included for Dependent Child 3	
Name:_____ Date of Birth: ___-___-____ Gender: M or F Dependent a full-time student? Yes ☐ No ☐ Dependent eligible for coverage through their employer? Yes ☐ No ☐ Medical or MERP ☐ Dental ☐ Vision ☐	☐ Copy of birth certificate/adoption paperwork/court order ☐ (If applicable) Copy of Social Security or physician certification of disability ☐ (If Age 19-24 and adding to dental) Proof of full-time student status	HR Use Only

Dependent Child 4	Documentation Included for Dependent Child 4	
Name:_____ Date of Birth: ___-___-____ Gender: M or F Dependent a full-time student? Yes ☐ No ☐ Dependent eligible for coverage through their employer? Yes ☐ No ☐ Medical or MERP ☐ Dental ☐ Vision ☐	☐ Copy of birth certificate/adoption paperwork/court order ☐ (If applicable) Copy of Social Security or physician certification of disability ☐ (If Age 19-24 and adding to dental) Proof of full-time student status	HR Use Only

E. Authorization:

I have read and understand all eligibility requirements set forth by Hamilton County. I have been informed of my benefit options and costs. I agree to pay required contributions, if applicable, through payroll deductions. I understand if I enroll in a medical insurance plan I certify that I do not have Alternate Coverage available to me at this time. I understand that I may only change my elections if I have a qualifying event and that only changes consistent with that event are allowed. I understand that I must notify my department payroll representative of my qualifying event within 31 days of the event or I may not make any changes. My signature below indicates the information set forth on this form is true and complete to the best of my knowledge. Any false statements on this form shall be considered grounds for discipline, up to and including termination.

Signature: _____ Date: _____

HR USE ONLY:	
HRP: _____	___/___/___
Deductions: _____	___/___/___
Scanned: _____	___/___/___
COBRA: _____	___/___/___
MERP: _____	___/___/___